The Repetition & Avoidance Quarterly

Volume Ten, Number One **The Washington State Veterans PTSD Program** **Summer, 2005**

VA Announces Plan to Review PTSD Claims —-Criterion A at Issue for Claims in 1999-2004

In an announcement that has been long anticipated by many veterans, the VA declared that it will begin a year-long review in September of 72,000 PTSD cases that involved claims made between 1999 and 2004. In an Associated Press story (8/11/2005) by Rebecca Carroll, it was noted that there was an 80% rise in PTSD claims during that era, whereas all types of disability claims rose only 12%. The AP reporter noted that the VA announcement expressed the intention of examining cases for the required medical evidence of a stressor. "If the current review finds a veteran's claim does not include adequate proof of a 'stressor'—the specific event or events that trigger the mental illness—the veteran will be asked to provide more information and could ultimately lose benefits." She reports that the "VA said it would work with vets to help them prove their cases. It will also be on guard for possible fraud—one vet in the sample reviewed last spring submitted as evidence a personal account written by someone else and published on the Internet."

The AP article stated that the "inspector general's report last May found that more than 25 percent of the PTSD cases reviewed lacked adequate proof of a service-related stressor." It also quoted Col. Charles Hoge, chief of psychiatry and behavior services at Walter Reed Army Institute of Research as stating that "while most service members with PTSD can identify incidents that affected them deeply...the reality is that there are also stressors that are ongoing."

An important aspect of this story is that the VA is not reevaluating the PTSD diagnosis, per se, in the claims, but the evidence of trauma, the so-called Criterion A of the diagnostic category 309.81 of the DSM. The fact that PTSD has been diagnosed is apparently not at issue in the pending review. What seems at issue for the 72,000 veterans is whether the federal government will take responsibility for the disorder. To do so, it will be upon the veteran to prove that the traumatic event took place.

Comment

The AP story states, "The VA said it would work with vets to help them prove their cases." The question that immediately arises is whether the VA will take an active role or a passive one, waiting for the veteran to pin down a researchable event.

This move by the VA represents a predictable contraction of responsibility for the damage done by war. The lighter the long term cost of war, of course, the easier it is to justify. The AP story observed that the current Iraq War, like the Vietnam War, was an accumulation of stressors, so that the vulnerability of a GI serving a tour is increased as the months wear on.

Therapists find the problem of identifying a provable stressor for support personnel in combat zones to be more difficult. The harassing fire of rockets and mortars into compounds was commonplace during the Vietnam War, but a specific explosion that impacted any individual was unlikely to be documented.

We can see that early screening of combatants and veterans for PTSD has the advantage of access to the still fresh facts and witnesses, a luxury that no longer exists for veterans of more distant wars. The sticky problem with PTSD in war veterans, however, is the abundant evidence that the disorder can have a long delay in onset, reducing the likelihood of early evidence gathering.

It is demeaning to veterans that they are accused of fraud by association with a few cases that prove to be concocted stories about stressors. We certainly see that PTSD has an ebb and flow quality depending on the challenges of stress in a veteran's life. It seems almost a majority of veterans who receive PTSD disabilities have felt an ominous foreboding that the disability would be revoked. Now it is conceivable that the VA might well say, we agree that you have PTSD, but you can't prove it comes as a result of military service, so we will no longer give you compensation. Yet, in a combat support role, the GI might well be asked to pitch in outside his regular MOS function, for instance to help sort bodies or ride shotgun on a convoy. To refuse, to say, no, that might get me traumatized in an undocumented event, would probably mean court martial for dereliction of duty. EE ##

Westside VA C&P Evaluations to be Contracted to a Private Corporation

For some time the veterans on the east side of Washington state have been sent for C&P exams related to PTSD claims to a doctor employed by a private corporation, QTC Medical Services. Veterans on the west side of the Cascades have been evaluated at the Seattle or American Lake hospital compounds of the Puget Sound Health Care System. In the latter case, the hospital C&P system contracted with individual doctors, psychologists or psychiatrists, who were paid separately for each case. Usually the evaluation took place in a hospital office where the doctor would review the claim material and interview the veteran. The system had the drawback, that was significant for some veterans, of requiring the veteran to travel to the hospital for the exam, a task that was seen as stressful in itself. The report of the C&P exam was then included with the claim material to be adjudicated and was regarded as the federal government's official document, giving it the status of forensic evidence.

Much comment has been generated about former VA director Anthony Principi's role in the company that was granted the contracts on the eastern and now the western areas of Washington state. Mr. Principi was president of QTC when he took office as Secretary of the Department of Veterans Affairs in 2002. He resigned the Bush appointment at the end of 2004. Mr. Principi is currently in the press as Chairman of the Military Base Realignment and Closure Commission.

A local VA official confirmed that QTC will take over "most" C&P exams—not just PTSD—beginning October 1, 2005.

The effect of granting one contract to a single company such as QTC Medical Services for conducting C&P exams, instead of contracting with individual professionals, remains to be seen. One could wish for data that would show ratio of claims made vs. claims granted for the years before and during QTC involvement. Much depends of the quality of the professionals employed by QTC, particularly on the depth of the doctor's knowledge of PTSD and his or her ability to relate to issues of war veterans. Just the ability to diagnose PTSD is not enough, the C&P examiner should have knowledge of referral resources for veterans.

If the doctor is paid a larger fee for a quick turn-around in submitting the report, it is important to understand what the effect will be on the types of errors that are possible. Type one error would be the doctor diagnosing PTSD when the disorder is not present. Type two error is when the doctor fails to diagnose PTSD, when it is indeed present. Type one error costs the federal government money, type two error has a profound cost for the veteran and his or her way of life. We hope that QTC Medical Services makes its employees aware of the gravity of their work. EE ##

Washington National Guard Family Activity Days Yield Remarkable Results

Routine readers of this quarterly will remember that the major veteran treatment entities in Washington State (VAMC, Vet Centers, and the WDVA PTSD Contractor Program) have been intensely involved in the drill weekend outreach efforts to the Washington State National Guard and some of the reserve units around the state. As of this printing, 16 of the 23 FAD or Family Activity Day events have been completed. Over 1,645 guard members have been surveyed using the Department of Defense post deployment medical and behavioral health survey tool. Forty-five per cent of the returnees were identified as having some type of behavioral health issue, that is to say, they endorsed items that triggered the need for an interview by a readjustment counselor. These trigger items include having suicidal thoughts or requesting to see a counselor now. If no triggering item was marked, a returnee can also be identified by high scores on the PTSD, depression, anxiety, potential for spouse abuse, and substance misuse scales or individual items denoting these issues.

The survey includes medical questions, which can activate the need for physical health and health habit counseling; Smoking, drinking, hypertension, and positive family history are included as medical pathways to closer review and consideration for follow up.

The salient feature of this important post-deployment work is the rate of referral to a counselor for behavioral health issues. Presently, 43% of those surveyed are referred to a provider for stress and readjustment services. This does not mean that 43% have PTSD. Presently we are considering ways to make certain returnees who are referred for counseling actually followed through with the professional suggestion.

The guard members will potentially continue to "incubate" within the homecoming process. For many, the war and homecoming issues will combine and form a new view of the world and the underlying assumptions holding us all near and connected to each other. Most will resolve these changes into their world view, and return to relatively normal lives. Others will need to work on issues now and in the future. As one veteran recently put it, "The outreach that you provided has started me on a path that is already helping me feel more relaxed and free of stress. I know the road is not going to be smooth at times, but I have an expectation that I will progressively renew my trust in myself and others. Without counseling, I would not be here today, and would have taken a radically wrong fork in the road of my life."

The other FAD service venders have reported significant service levels to include: 17% service connection claims for various issues; 21% assisted with employment needs; 30% offered information and assistance regarding VHA, and nearly all receiving information about TriCare and other benefits. The behavioral and mental health teams who have participated in these events have uniformly come away from the FAD events with a deep sense of respect for the efforts of our state's guard members. Guard and reserve members have made extreme sacrifices that have and will affect their lives, families, livelihoods, and their own sense of who they are from this time forward. The best we can do is offer them support, direction, and our sincere thanks. *TS*

Pathways to PTSD Identified in Children

Two articles in the July 2005 issue of the *American Journal of Psychiatry* feature the use of Path Analytic Models to identify the variables leading to PTSD in children. Glen Saxe, M.D., et al, published their research on children with burns ["Pathways to PTSD, Part 1: Children With Burns," 162(7), 1299-1304], and Julie Kaplow, Ph.D., et al., studied sexually abused children ["Pathways to PTSD, Part II: Sexually Abused Children," 162 (7), 1305-1310].

Burned Children

Glen Saxe, et al, studied a group of 72 children with acute burns for whom the average length of stay at the Shriners Burn Hospital in Boston was 25 days. The children were interviewed around 10 days after admission. Follow-up interviews and assessments were performed in the children's homes after 3 months. The authors report that the results of path analysis indicated two "direct" pathways to PTSD in the children: "1) acute separation anxiety… and 2) acute dissociation" (p. 1300).

Saxe, et al., discuss their findings: "The magnitude of the trauma, measured by the size of the burn, was not related to PTSD directly but exerted its influence indirectly through both pathways. The pathway mediated by separation anxiety was influenced by the acute pain response. This pathway was also influenced by the size of the burn and was inversely related to the age of the child. The pathway mediated by the acute dissociative response was influenced only by the size of the burn" (p. 1301).

The authors speculate that the independence of the two pathways suggest two different "biobehavioral systems" contribute to the children's PTSD. They cite research that suggests that the anxiety symptoms operate on the sympathetically mediated fight-or-flight response, whereas the dissociative symptoms are mediated by the "freeze" response of the parasympathetic system. They note (p. 1302) that "no direct relationship between separation anxiety and dissociation was found in our model." They add, "our data suggest that *both* anxiety and dissociative symptoms independently contribute to the risk for PTSD."

In discussing their findings, Saxe, et al., advocate for keeping parents and burned children together to reduce separation anxiety, and they note that the administration of morphine to acutely burned children "diminishes PTSD symptoms over time" (p. 1302).

Sexually Abused Children

Julie Kaplow, et al, examined the two pathways to PTSD of anxiety and dissociation in 156 sexually abused children during their initial forensic interview and from a follow-up interview. A path analysis was performed. "The results indicate three direct paths to PTSD symptoms from the disclosure reactions: avoidance, dissociation, and anxiety" (p. 1307). The authors observed "anxiety/arousal served as a mediator between life stress and PTSD and between age at onset and PTSD. In addition, avoidance served as a mediator between age and PTSD and between gender and PTSD. Dissociation was not only a direct predictor of PTSD but also an indirect predictor of PTSD symptoms by way of anxiety symptoms" (p. 1307). Kaplow, et al., considered that dissociation was the strongest predictor of PTSD symptoms in this group of children. They observed "Dissociation is significantly associated with anxiety/arousal, whereas anxiety/arousal is not significantly associated with dissociation" (p. 1308). The authors noted that age at onset negatively predicted anxiety and arousal symptoms, but that those symptoms were positively related to life stress. They observed that younger children are more likely to be avoidant upon disclosure and that boys are more likely to exhibit avoidant behaviors upon disclosure.

Kaplow, et al., suggest that children who disclose sexual abuse and who display symptoms of anxiety/arousal, avoidance and dissociation upon disclosure are likely to need follow-up treatment to prevent PTSD. They write, "Consistent with reports of the outcomes of PTSD treatment…, the current findings suggest that treatments encouraging open expression of thoughts and feelings surrounding the abuse can help to deter growth in PTSD symptoms over time. Further, the relative independence of dissociative and anxiety/arousal pathways to PTSD symptoms suggests the possibility for targeted treatments aimed at particular biobehavioral systems" (p. 1309).

Comment

The three sets of symptoms that diagnose PTSD are repetition, avoidance, and hyperarousal. The suggestions made by these two path analytic research efforts aimed at traumatized children is that there are two different biological pathways that give rise to PTSD: the sympathetic arousal system, and the parasympathetic system involving avoidance and dissociation. Clinicians need a little bit of both to diagnose a client with PTSD. We hear reports of battlefield dissociation and we sometimes find adult clients who tend to dissociation. We see avoidance practiced in ways that prolong symptom manifestations, such as substance use and social isolation.

The symptoms of hyperarousal are most commonly treated with direct methods: medication, relaxation and meditation, ideally in conjunction with an exploration of the trauma associated material, leading to a gradual desensitization. The avoidance symptoms are quite the more difficult to treat. The client tends not to report symptom intrusion, either because he or she willfully downplays or avoids the report, or because the client forgets the experiences. Clients who have avoidance as their main symptom expression can, in a way, collude with the therapist to talk about various entertaining and interesting material, not the least of which may include polemical discussion of the current war and its political ramifications. The therapist must ride a fine line between advocating for social involvement for the client and inquiring about the manifestation of symptoms. EE ##

PTSD and Substance Use Disorders Examined for Common Neurobiologic Pathways

Researchers from the University of South Carolina have examined the co-occurrence of disorders such as depression, ADHD, PTSD, and schizophrenia with substance use disorders, by tracing the common neurological pathways. Kathleen Brady and Rajita Sinha published their article in the *American Journal of Psychiatry* [2005, 162(8), 1483-1491]. The authors ask why substance use and other mental disorders so often co-occur. It is important that they include nicotine use among the disorders more commonly thought of as substances of abuse.

Authors Brady and Sinha write, "In this article, we conceptualize chronic distress as a central construct underlying the association of each of these four psychiatric disorders with substance use disorders and examine emerging neurobiological findings within this framework" (p. 1483). They state, "It is important to note that different substances of abuse have widely varying effects on neurobiological systems. Cocain and amphetamines have a stimulating effect on catecholaminergic systems. Opioid analgesic drugs acts through a complex system of opioid receptors, and nicotine acts through specific nicotinic receptors distributed throughout the central and peripheral nervous systems" (p. 1484).

Regarding depression, the authors state that "Individuals with major depression are more likely to develop substance use disorders, and individuals with substance use disorders are at greater risk for the development of major depression compared to the general population…. Clinical similarities exist between major depression and substance use disorders. Depressive symptoms are commonly reported during acute and chronic withdrawal from drugs of abuse. Irritability, sleep difficulties, anxiety, and trouble with attention/concentration are associated with both protracted withdrawal states and major depression" (p. 1485). They add that "Evidence of altered neuroendocrine response to stress challenges in substance use disorders is consistent with clinical observations that individuals with substance use disorder have difficulty managing stressful situations and emotional distress states and often relapse in the face of stressful situations" (p. 1486).

Brady and Sinha find similar common ground with PTSD and substance use disorders. "Substance intoxication may heighten the likelihood of developing PTSD. Furthermore, chronic substance use and withdrawal may increase anxiety/arousal states, making it more likely that individuals with substance use disorders will develop PTSD after trauma exposure. On the other hand, PTSD could increase the risk of developing a substance use disorder, because individuals may abuse substances in an attempt to relieve symptoms of PTSD" (p. 1487). The authors explain the process of common pathways. "Specifically substance use or withdrawal or other stress may stimulate CRF [corticotrophin-releasing factor] release in the locus ceruleus, leading to the release of norepinephrine in the cortex, which would, in turn, stimulate the release of CRF in the hypothalamus and amygdala. This interaction could help to explain the attempt to self-medicate PTSD symptoms with substances of abuse, the worsening of PTSD symptoms during substance withdrawal, and the increase in vulnerability to the development of PTSD in traumatized individuals with substance use disorders" (p. 1488).

The review notes a "high prevalence of the co-morbidity of substance use disorders and PTSD" in a number of reports. "Initial reports focused on veterans with PTSD, of whom 64%-84% met the criteria for a lifetime alcohol use disorder and 40%-44% met the criteria for a lifetime drug use disorder, including nicotine dependence…" (p. 1487). They observe that in the non-veteran population, the prevalence of these co-morbid disorders range from 22% to 43%.

Brady and Sinha deal with the nicotine dependence in their discussion of schizophrenia. They estimate that 70% to 90% of individuals with chronic schizophrenia are nicotine dependent. They observe that other authors have noted that the high rates of cigarette smoking in schizophrenic patients may be related to the effects of smoking in alleviating some of the cognitive dysfunction associated with the presumed hypofunctionality of cortical dopamine systems in schizophrenia.

The authors summarize their review by stating "Although the nature of the relationship between psychiatric disorders and substance use disorders is complex and multifaceted, there are likely to be unifying constructs. Neuroadaptations in brain stress and reward pathways associated with chronic stress may predispose or unmask a vulnerability to psychiatric disorders, substance use disorders, or both" (p. 1490).

Comment

Explorations such as put forth by Brady and Sinha dovetail nicely with the research of McFall, et al., reviewed on page 5 of this *RAQ*. One can see how the event or events that lead to the development of PTSD may be intimately involved in making one vulnerable to substance use for emotional control of symptoms. Other researchers have noted the circuitous route of this complex puzzle, that substance use, particularly of illicit drugs, can lead to the circumstances of being psychologically traumatized. It is also important to note that the regular use of such substances can lead to a present-centered perspective that, in turn, can lead to the subtle PTSD symptom of having no sense of future. Chronic substance use, then, would seem to provoke a poor orientation toward planning and carrying out long term strategies that would lead to the furtherance of one's well-being. EE ##

Seattle VA PTSD Program Introduces Smoking Cessation as Part of PTSD Treatment

In a study published in the July *American Journal of Psychiatry*, researchers at the Seattle Puget Sound Health Care System (aka, the VA Hospital) PTSD Program found that veterans who were treated for smoking cessation while they were also being treated for PTSD, were significantly more successful in quitting smoking than veterans who were treated for smoking cessation alone. Miles McFall and his colleagues ["Improving the Rates of Quitting Smoking for Veterans with Posttraumatic Stress Disorder," 2005, 162(7), 1311-1319] recruited 66 subjects from the PTSD clinic to be included in the research if they smoked 10 or more cigarettes per day. Half of the subjects (33) were assigned to "Integrated Care" and received PTSD counseling and individual counseling for smoking cessation. Both groups were treated with the same medication prescribing options. The "Usual Standard of Care" option was a comparison condition at the smoking cessation clinic. All subjects received usual psychotherapy from their case managers. Patients were compared for abstinence at 2, 4, 6, and 9 month intervals, along with PTSD Checklist and Beck Depression Inventory at 6 and 9 month follow-ups.

The authors reported that "At each assessment interval, the odds of not smoking at that interval were over five times greater for the subjects in integrated care than the subjects in usual standard of care…" (p. 1314). McFall, et al., comment: "This study demonstrated the feasibility of training mental health providers to integrate guideline-based smoking cessation treatment into mental health care for veterans with PTSD. PTSD clinic prescribers readily incorporated the delivery of tobacco-cessation medications into their clinical practice." The authors add, "The integrated model of smoking-cessation treatment tested here was more effective for PTSD patients than for care provided by VA smoking-cessation specialists…" (p. 1314).

Comment

The subject of smoking and PTSD in war veterans is one that relates directly to federal government responsibility for the smoking habits of those who were introduced to smoking in the service. It was a not uncommon practice to give smoke breaks during training, keeping the ones who didn't smoke busy with tasks. It was a common practice during the eras of World War II, the Korean War, and the Vietnam War to give 4-packs of cigarettes free with C-Rations. (One can still get good deals on cigarettes at the local base exchange.) Given the addictive nature of nicotine, many in the military began long term habits. This scene is especially poignant when we consider that combatants were offered free cigarettes at a time when life expectancy was abbreviated and anxiety was high. It was also a time for those in late adolescence when collective peer influence was strongest. Regrettably the federal government has rejected the connection between illnesses linked to smoking and service connection.

The work of McFall, et al., is welcomed because it links smoking cessation help with PTSD counseling and shows that such a linkage is more effective than smoking cessation treatment separate from PTSD treatment.

Back in the days when clients were allowed to smoke in groups, it was apparent to this reviewer that one could predict when a client would reach for a cigarette—usually at the time when strong emotions were evoked. One possible interpretation of the results that show PTSD counseling improves smoking treatment compliance is that PTSD and smoking are paired together in the treatment procedure, each lending significance to the other. McFall, et al., state that the "service delivery study was conducted in the spirit of a clinical effectiveness trail in order to promote generalization to 'real world' health care settings" (p. 1317).

Looking at old movies of the previous war eras, we appreciate how different the attitude toward smoking was in the recent past. It was seen as a relief of tension, a break, a time to share with others and reflect. The way one smoked reflected one's personality style. When Tyrone Power's war veteran character in the film version of *The Sun Also Rises* is told that he's been made impotent as the result of a wound, he pauses, then asks the doctor, "I can still smoke, can't I?" Veterans who have gotten control of drinking, reformed their lifestyle to incorporate better health care, sometimes cling to smoking as if it were their last right (pun intended). The idea that the same discipline is required that accompanies the management of PTSD symptoms, links, for many veterans, the common genesis of the two disorders.

We encourage the federal government in their recent spirit of reform to look at its responsibility for the diseases that result from long term smoking. EE ##

RAQ Retort

The *Journal of Traumatic Stress* doesn't invite comment, but we do. If you find that you have something to add to our articles, either as retort or elaboration, you are invited to communicate via letter or Email. And if you have a workshop or a book experience to tout, rave or warn us about, the *RAQ* may play a role. Your contributions will make a difference. Email or write to WDVA.

emmettearly@msn.com
tom@dva.wa.gov

Complex PTSD and the Self Trauma Model— John Briere Advocates for Relationship in Therapy

John Briere, Ph.D., a leading figure in the development of a therapy model for the treatment of complex PTSD, gave a two-day workshop in Seattle during which he made a strong case for the significance of the therapeutic relationship in the treatment of complex PTSD. Dr. Briere is an associate professor at USC and director of the Psychological Trauma Program in LA County and the USC hospital. He was president of the International Society for Traumatic Stress Studies during the 9/11 terrorist strikes.

He stated categorically, "The only way you can really help someone is to form a relationship." His two day workshop at SeaTac, September 23-24, 2005, was on the topic of psychotherapy for complex PTSD. On the first day he laid out a theoretical framework and background for the concept of complex PTSD. On the second day he spent six hours discussing his theory for the treatment of the disorder, specifically the Self Trauma Model, which he characterized humorously as "relational cognitive behavioral therapy."

John Briere is a very bright, clever, witty, extemporaneous speaker, working from a skeleton outline on his PowerPoint. As a professional teacher, he spoke otherwise without notes or prompts six hours each day, for two consecutive days, although in the last hours of his second day, he began to falter and lose track of his thoughts. He often created a surrealistic effect by standing between his PowerPoint projector and the screen, so that the words of his outline were projected onto his body. He would raise his arm and we'd see "Relational disturbance" appear on his shirtsleeve. I don't think he was doing this theatrically, although if he worked it into his act, it would be very dramatic.

Interestingly, while Dr. Briere's vocabulary was cognitive and behavioral, he admitted that he, himself, was in psychoanalysis with his shrink, Bernie, and he applied his ideas using a psychodynamic model for longer term psychotherapy. He often in his lectures contrasted his thinking with the other leaders in the treatment field, namely Marcia Lanihan, Edna Foa and the EMDR school.

Dr. Briere cited his experience in treatment and supervision working in South Central LA and with the treatment of victims of torture. Trauma, he said, was not normally distributed in America. His theory for the treatment of complex PTSD will be backed up with a book, soon to be released, *Principles of Trauma Therapy.* He also has his own website, *johnbriere.com*, where he lists other references to his works and where he provides links to data bases, such as *PILOTS.*

In his lectures, Dr. Briere was critical of the various diagnostic manual editions. He faulted DSM-IV for focusing on one trauma and not taking into account the impact of cumulative and multiple traumas. He also noted the limitations of outcome research, which was typically limited to short term tracking and the necessity of exclusionary criteria, which tends to glean out persons with comorbid disorders, which is what constitutes the majority of persons with complex PTSD.

Dr. Briere paid particular attention to the effects of early developmental trauma exposure. He used the metaphor of the "good house-bad house" comparison, and qualified his remarks by contending, somewhat humorously, that only about 7% of the population in America comes from the good house. Actually, he said, there is a continuum. If one comes from the good house, one has secure attachment and good affect regulation, both of which are required to handle the traumatic events of later years. He also noted the significant bifurcation between non-interpersonal trauma, and interpersonal trauma. When he said this, I imagined the difference in significance on intake history gathering between having a fire in the good house, versus a fire in the bad house. Dr. Briere made repeated mention of the salient difference between the traumas of what was done, versus the traumas of what was not done, specifically citing the effects of abandonment and neglect. "What wasn't done for the child is more important than what was done." He also gave emphasis in his theoretical outline to the importance in treatment of differentiating between implicit and explicit memories. Explicit memories are verbally mediated, accessible in the sense of being subject to voluntary recall and the fact that one can remember both words and context. This memory system is mediated largely by the hippocampus, residing in the brain's limbic system. Implicit memory is non-verbal, composed of feelings and sensations, but without the "you" of the subject. Implicit memory is not voluntarily accessible, but is rather a triggered experience and mediated by the brain's amygdaloid system. He made it clear that one cannot convert implicit memory into explicit memory and acknowledged that exploring traumatic memory is something of a two-edged sword, with the risk of making one's PTSD symptoms worse, although, in his therapy model, the worsening would only be in the short term. "We work in treatment with explicit memories that trigger the implicit."

Dr. Briere took his audience through exercises by challenging us to apply his ideas to various examples, which he mimicked in a manner of a stand-up comedian. In this manner he discussed behavioral avoidance strategies, particularly what he termed "effortful avoidance," such as thought suppression, denial, and intellectualization. He noted that substance abuse can become effortful avoidance, citing the high correlation between IV drug use and trauma. He outlined the various forms of dissociation, noting that while not everybody who has PTSD has a history of dissociation, more than 90% of those who dissociate have a trauma history. He defined dissociation as a "defensive alteration in awareness," and described numbing, derealization, DID, "spacing out," depersonalization, disengagement, and fugue states, as examples of dissociation.

(Continued on page 7, see *Briere.)*

***(Briere*, Continued from page 6.)**

Throughout his lectures, Dr. Briere was positive about the treatment of complex PTSD. It was his contention that PTSD symptoms are "symptoms of recovery," and when the symptom works, one stops having symptoms. Thus, he said, flashbacks are a good sign! He characterized hyperarousal as the failure to habituate. He said that the central injuries of trauma are self capacity injuries: identity disturbance, affect dysregulation, and relational problems. Dr. Briere asserted that numbing was the most ominous PTSD symptom, and that the avoidance symptoms generally lead to chronicity, mainly because "effortful avoidance blocks exposure."

Although Dr. Briere contended that he didn't know what the goal of treatment is, he did indicate that the acquisition of affect regulation was central to healing. As he said of one patient he cited as an example, "now she has the capacity to feel horrible." He said, "the therapeutic relationship is a specific treatment phenomenon." The therapist works with what he characterized as a "therapeutic window," which he framed as taking place within the therapy session, and during the course of treatment. The central components of treatment consisted of exposure, activation, disparity (that is, the non reinforcement of conditioned emotional responses within the safety of the therapy session), counter-conditioning, and extinction and resolution. "If you don't have disparity in trauma environments, one risks re-traumatizing the [client]." Specifically, he defined disparity as "the ability to have emotional expression in a safe environment."

Dr. Briere gave much emphasis in the second day of his lecture on the metaphor of the "therapeutic window" during the treatment hour, in which one builds up the amount of trauma exposure so that it occurs about midway through the hour, then tapers down the emotional associations so that the client may leave the office feeling contained in safety. Dr. Briere repeatedly emphasized that when the therapist is in doubt, "do less." Activation of trauma-associated affect rests in the details of the trauma, and the most effective therapeutic technique is questioning, which increase the content of the context, but, he warned, "only ask questions that inhabit the level of activation."

Dr. Briere acknowledged that it seemed like a paradox that exploring a trauma memory for its details, which would increase the size of the memory, would result in recovery. This is only because of the safety of the treatment environment. For this reason, Dr. Briere was sympathetic to a young woman in the audience who worked in a hospital ward situation and could only treat patients in a group modality. He expressed his opinion that the form of therapy that he was endorsing would not work in group setting, because it lacked the safety that was required for the establishment of disparity, i.e., the focus on trauma memory in a safe environment.

There aren't many workshops that would draw this old psychologist to miss a day of income and a day off and feel like I am the better for the effort. I feel that John Briere has described in an orderly and sensible model, the kind of individual psychotherapy I do and have observed others doing in this 25-year evolution of treatment for PTSD. EE ##

Social Work Society Offers Services to Returning Veterans

By Frank Kokorowski, MSW

The Washington State Society for Clinical Social Work (WSSCSW) has initiated a veterans outreach program for returning OIF and OEF veterans and family members. The Society is affiliated nationally with the Clinical Social Work Federation. To date 24 members of WSSCSW have offered their services to veterans on a pro-bono basis, sliding scale, or insurance supported. Like WDVA contractors, the Society members are primarily private practitioners and have committed clinical slots to veterans with an excellent referral, monitoring, and consultation system for support.

This offer started well over a year ago. In 2004, I was approached by and met with a group from the Society requesting more information about veteran issues, expressing an interest in how to appropriately and meaningfully get involved. This move was influenced by an experience Society member, Laura Groshong, had at an airport waiting for a connecting flight. Laura was waiting near some soldiers, who were also waiting for a flight, and was very touched by the experiences they shared and the situations they described. This led to an effort on the part of Laura and other members that influenced the Society to seek ways to get more involved with serving veterans.

At that time I was approached by the Society, the number of Iraq and Afghanistan veterans seeking clinical service through King County was minimal, although that is no longer the case. I encouraged WSSCSW to meet with VA Deployment Clinic staff at the Puget Sound Health Care System in Seattle and present their offer. Representatives of the Society did meet with the Deployment Clinic and Miles McFall, PhD, who embraced the Society's offer. A meeting with Tom Schumacher is also scheduled for late September. So far, referrals have been minimal, but clearly this will change as we move to the holiday season and the war drags on.

In an effort to learn more about veterans and their needs, the Society sponsored a panel presentation, featuring Steve Hunt, MD, as a VA representative, Chris Konzelman, from the National Guard, and myself. The conference was well attended and successful, leading to the dissemination of information on combat trauma among OIF and OEF veterans.

I applaud the Society and their heartfelt efforts to reach out to veterans. This is unique and touching to me. In 30 years of social work practice I have never seen a society step forward in this way. I welcome the WSSCSW to our family of service providing professionals.

Frank Kokorowski, MSW, is the mental health clinician for the King County Veterans Program.

PTSD Program Changes. Contractor added in Spokane, Mark Fischer Returns to Coordinate the Veterans Conservation Corps.

Dennis Pollack, Ph.D., New Contractor in Spokane

Sixty-one year old Psychologist, Dennis Pollack, has come on as contractor psychotherapist in Spokane. Dennis has had a private practice in Spokane for many years, about 25% of which is devoted to psychotherapy. His principle professional interest is in the field of forensic and vocational evaluations and psychological testing. Dennis received his Ph.D. from Michigan State University in clinical psychology. He grew up in northwest Indiana and attended the University of San Francisco for his undergraduate work. He completed his clinical psychology internship at Napa State Hospital in California and taught psychology at Illinois State University in Normal and at Gonzagga University in Spokane. Dennis also lectures and gives workshops on psychological testing and has several interesting ideas about birth order and the influence of the test administrator's orientation. He noted that he has a case that is appearing on the television documentary show "Dateline."

Dennis also performed C&P evaluations for QTC Medical Services in the Spokane area. He said that he stopped that work because he felt that QTC was providing incentives for a quick turn-around of reports by paying more if the evaluation report was returned within three days, less if the evaluator took more time to develop the report.

Dennis Pollack can be reached for appointments at 509-747-1456. ##

Mark Fischer, MS, Veterans Conservation Corps

As many contractors may remember, Mark Fischer was once a therapist in our program. He was lately given a half-time contract to head the Veterans Conservation Corps, funded by a 4-year bill that will connect veterans with salmon restoration projects around the state. According to Mark, veterans have an option of doing a variety of tasks, including work replanting, or removing invasive species, being a docent to visitors along salmon walks, doing more scientific lab, or hatchery work, or science field work. These jobs would be part time and voluntary on the part of the veteran. For more information, contractors or veterans should telephone Mark Fischer at 360-586-1073 or contact him by Email at markf@dva.wa.gov.

Mark Fischer earned his MS in Behavior Science/ Marriage/ Family/Child Counseling at Lavern College, in California. He was a therapist in the WDVA PTSD Program for 14 years, based in Olympia. Mark also has a BS in biology and, after he left WDVA, he worked for the Puget Sound Restoration Fund managing a shell fish farm.

Mark stated that the emphasis in the Veterans Conservation Corps will be to hook up veterans who have been in treatment for PTSD with Salmon Enhancement Groups, who will put the veteran to work in an area he or she might prefer. ##

Keith Meyer, M.S., LMHC, New Contractor in Olympia

Keith Meyer has been added as a WDVA counselor to serve Olympia. Keith is a licensed mental health counselor in the state of Washington with a master's degree in psychology from Radford University. He has 17 years experience providing both inpatient and outpatient counseling to families and individuals with mental health and drug or alcohol issues. His approach is psychodynamic and cognitive-behavioral. Keith states that he will work with his clients to set mutual goals that are beneficial to them and their life circumstances. Keith's philosophy of treatment is that people can work through issues and emotional blocks that allow them the freedom and creativity to solve problems. ##

VA Sponsors Conference to Discuss Health Problems of Returning Veterans

A Department of Veterans Affairs conference, "Caring for Post-Deployment Soldiers and Their Families: a Day–Long Conference to Discuss the Mental Health Needs of Soldiers Returning from Iraq and Afghanistan," is scheduled for November 4, 2005 in Canby Grove, Oregon. Tom Schumacher of WDVA was a participant in the planning and he is encouraging contractors to attend. The program will open with "A panel of Soldiers and National Guard Family Coordinators." They will be followed a keynote address by Michelle Sherman, Ph.D., who is director of the Family Mental Health Program at Oklahoma City VAMC. Her address will be followed by an address by Scott Babe, MD, "Perspectives of Reservists and Professionals: A mental health professionals talk about being deployed and providing care in the field and at home." After lunch, there will be a panel discussion on Family Issues/Assessment/Intervention," moderated by James Boehnlein. The afternoon of the conference will also feature panels on "Diagnosis and Treatment" and on "Co-Morbidity."

The goals and objectives of the conference are articulated in an advance notice: "At the conclusion of this conference, attendees should be able to describe the most common medical and psychiatric problems among OEF/OIF returnees; discuss the challenges that individuals and families face in reintegration; identify effective treatment approaches; and describe existing resources to address social, financial, educational, and vocational needs."

Fee for the 6-hour program is $25.00 and WDVA contractors are encouraged to use their CE provision in their contracts to cover expenses, such as reimburse for travel mileage, no small expense these days. Those with questions may email *shannon.squire@med.va.gov* or call Shannon Squire at 503-220-3481. ##

Gestalt Therapy Advocated for PTSD Treatment

Writing in the *Vet Center Voice* [2005, 26(3), 30-31], David McPeak, a team leader at the Pittsburgh, PA, Vet Center advocated for the use of Gestalt psychotherapy in the treatment of veterans with PTSD. He states, "Embodying Gestalt therapy into my treatment approach has allowed me to help veterans move forward out of the past, and into healthier, more productive lives" (p. 30).

The author writes: "Gestalt therapy's view of posttraumatic stress disorder is that it is an intense form of unfinished business from the past clamoring for attention in the present. This unfinished business can impact negatively on a person's ability to go into the environment to obtain what it is that he or she wants" (p. 30). He cited, for example, that in prolonged combat, deaths and other painful moments go unresolved and remain unfinished. He observed the problems related to lack of awareness of coping methods involving "resistance to contact," and discussed Gestalt definitions of introjects (beliefs), deflection (distracting behavior, excessive language), confluence (resistance in confronting beliefs), projection (false attribution), and retroflection (self restriction) as terms for use in working with veterans in psychotherapy.

The author writes that Gestalt therapy is a "theory of individuals becoming aware and working through their resistance to going into the environment and, especially, outward to other people to ask for support, comfort and nutrients we all need to prosper in life" (p. 31).

Comment

One of the difficulties of Gestalt therapy techniques is the knowledge we now have of the neurobiology of PTSD. If it is correct to say that traumatic memory consists of a complex of neurons that became connected as a result of an overwhelming event, and that recalling that memory in the sense of thinking it through, looking at what happened and what could have happened, or perhaps puzzling over absences of memory of what happened, contacting others who were there, (or for childhood traumas, perhaps confronting the perpetrators of a traumatic assault), probably results in expanding that neural complex of memory. If each recall and revisiting of the traumatic event in this fashion makes the memory expand, does that not run the risk of increasing PTSD symptoms?

Gestalt and other psychodynamic theories conjecture that closure can occur through such effort, putting the memory to rest. However, it is also possible that the process of seeking closure may result in making the memory more prominent and potentially more troublesome, if the treatment modality is a time-limited group. EE ##

Book Review:

Sir Gawain and the Green Knight—A War Veteran Interpretation

Reviewed by Emmett Early

Sir Gawain and the Green Knight is a rare piece of early English literature of unknown authorship. It was probably recorded from oral tradition in the later Middle Ages and has elements of folk tradition involving solstice festivals and Arthurian mythology. The story is charming for its adherence to courtly love and for maintaining the magic of enchantment. Poet W.S. Merwin's translation (2004) is an easy read in modern English. His introduction gives a nice literary history of the epic.

I have found the story relevant to the modern combat veteran, particularly regarding the problems presented by adherence to duty and the emotion of shame regarding choices and circumstances of combat.

Gawain is a knight who is present at King Arthur's Round Table celebrating the winter solstice when an awesome event occurs. A gigantic knight rides into the court bearing a huge battle ax. (The cutting edge is about 4.5 feet). Even more spectacular is the fact that the fearsome knight and his horse are both bright green. The associations are at once to death and to vegetation (life). The knight challenges the king and any of his knights. He offers the use of his ax to anyone who would cut off the Green Knight's head on the condition that that person must seek out the knight next solstice and accept the same blow in return. All at the court are awestruck, and as the king rises to accept the challenge, Gawain intercedes:

> "Gawain, sitting next to the Queen,
> Bowed to the King then:
> 'I will keep my words plain.
> I ask for this battle to be mine.'"
> (p. 25)

Gawain agrees to the fight in the place of the king. He cuts off the head of the Green Knight. However, the giant reaches down and picks up his bleeding head by his green hair, leaps onto his horse and calls out his challenge to Gawain, directing him to go to a place, the Green Chapel, a year from that date to receive his fate.

"He slept in his armor"

When the time passed and winter returns, Gawain sets off to find the Green Knight. The epic emphasizes Gawain's hardship. He faces peril, loneliness, and deprivation in his search, for he does not know where the Green Chapel is located. Merwin uses a wonderfully simple line that captures the war veteran's plight: "he slept in his armor\among naked rocks more than enough nights…" (p. 53).

Eventually he arrives at a castle where he is given shelter and a promise to be taken to the Green Knight's chapel in time for his end of the year appointment. In the meantime, he is entertained by the lord and the lady. The lord of the castle recognizes Gawain as "a prince without peer\where bold men fight" (p. 61) and proposes a game between he and Gawain: they will exchange whatever they gain that day. The lord engages in a hunt and on each of three successive days brings in his kill and gives it to Gawain. The poem describes each day's hunt in gruesome detail; the killing and slaughtering of deer on the first day, the dismemberment of a giant boar on the second day, and the skinning of a wily fox on the third day. Gawain stays at the castle during the hunts. Each day the lady of the castle visits him in his bedchamber. Each time she visits she offers her body to the knight and each time he refuses her with such graceful courtly language that she is not offended. Each day they kiss, first one, then two, and then three kisses. Thus, each time the lord of the castle returns to give Gawain his kill, Gawain kisses the lord, returning each in the number he was given by the lady of the castle.

Significantly, the lady insists on giving Gawain a gift on her last visit. She gives him her green belt, which she says carries the power to prevent death to its wearer. This gift Gawain secrets on his person and does not turn over to the lord. He rides off to the Green Knight's chapel with the sash wrapped around his waist: "to save himself when his time came to suffer\And wait for death with no sword to defend him or other blade" (p. 139).

Gawain rides off at this appointed time and is directed to the Green Chapel, which turns out to be a cave and a mound where the Green Knight is sharpening his blade. Gawain submits to the blow. First the Green Knight faints with his ax and Gawain winces. The Green Knight taunts him for flinching and makes him bow for a second blow. This he delivers without Gawain flinching, but delivers only a nick on the knight's neck.

The Green Knight, who is called "a wild monster with no use for mercy," spares Gawain. He reveals himself to be the lord of the castle he just left. The nick on his neck is for not giving the gift of the lady's green belt.

Gawain returns to Arthur's court in shame, although he is praised by everyone who hears his story. So admired was Gawain that the knights of the Round Table thereafter wore a bright green sash as a symbol of his bravery.

> "'Look, sire,' he said, and held up the belt,
> 'This ribbon belongs with the blame branded around my neck,
> This is the harm and loss that I have endured
> For the cowardice and coveting that I was caught in there.
> This is the token of the untruth I was taken in
> And I must wear it as long as I live,
> For no one can hide the wrong he does, nor be free of it,
> For if ever it takes hold, nothing can cut it away.'"
> (pp. 170-171)

I think of *Sir Gawain and the Green Knight* as a story of the war veteran who delivers the blow for the government and then must submit to his fate of dealing with the return blow, his life disrupted. The poem spends the heart of its story on the sharp contrast between the lady's tender offer of love, repeated more arduously each day, with the lord's rough hunts and detailed bloody slaughters. Gawain must accept both, but must accept only the lady's kisses, not her body. When she gives him her magic belt that guarantees his wellbeing, he breaks his ethical code and the rules of the game. This is his shame. He has survived by protecting his life. ##

Film Review:

Elevator to the Gallows—Louis Malle's First War Veteran Film

Reviewed by Emmett Early

When a nation engages in war, even wars on foreign soils, the impact is soon felt throughout the culture. Louis Malle made *Elevator to the Gallows (L'Ascenseur pour l'Echafaud*) in 1957 about a "parachutist" veteran of the French-Indo China War and the war in Algeria. He is an employee of a war profiteer and conspires to murder his boss. His co-conspirator and lover is the boss's wife, Florence Carala (Jeanne Moreau). The war veteran is Julien Travenier (Maurice Ronet). He is the epitome of cool, what we know now can be a product of heroin or emotional numbing (detachment). Julien carries out the murder by repelling off the side of the office building so that it appears the boss has committed suicide.

A very great attraction of this film is the unique original score on the soundtrack by Miles Davis, said to be an improvisation. He plays throughout the film with a quintet, featuring French musicians and Kenny Clarke on drums.

When Julien first puts the pistol in the boss's face, the old man says he doesn't believe Julien has the courage. "In war, yes. But not in more important things." The war profiteer soon learns that is not the case. Before he shoots him, Julien says, "How many millions did you make in Indo-China? And now in Algeria? Respect war, Mr. Carala, they are your family heirlooms."

Louis Malle fashions a terrific montage, cutting between the assassin, who is trapped in the office elevator, two young criminals who have stolen his car, and Florence, who wanders through the wet streets of Paris wondering what happened to her lover, with Miles Davis playing romantically in the atmosphere.

The young car thief poses as the war hero Julien Travenier, meets and eventually murders a German tourist and his girl friend. The police think Travenier killed them. The girl who accompanies the thief is an admirer of Julien, who, she says, has many war medals and "fabulous wounds."

Elevator to the Gallows was Malle's second film (his first was a documentary), and established him as an important director in the French New Wave. Louis Malle's career lasted until 1994, when he made *Vanya on 42nd Street*, and is marked by an impressive range and variety of important films. His second film about a war veteran misdirected by his emotions was *Alamo Bay*, which he made in 1984, about a Vietnam War veteran fighting to save his fishing boat on the Texas Gulf.

Elevator to the Gallows has a remarkable cool that is matched by the Miles Davis score and the war veteran's emotional control. The character of Jeanne Moreau duplicates that cool in her role as the classy woman picked up in a police sweep while wandering the streets. It is the kind of cool that captured many young viewers in late 1950s. (The film carried the ironic title *Frantic* in its 1957 U.S. release. A new release has just been announced to be in urban theaters soon.)

War Memories as Trap

I appreciate the symbolism of the war veteran, in this case a veteran of two French colonial wars, who becomes trapped while seeking revenge. *Elevator to the Gallows* gives us the impression that Julien Travenier is committing the murder out of love for Florence, but when he is about to kill the war monger boss, her husband, he speaks of his contempt for the war profiteering, and it is his cool control of his emotions that allows him to return to the scene of the crime to retrieve his repelling rope, only to be trapped in the process. What we see, often, among war veterans is a sense that they are stuck, trapped in their wartime emotions and memories.

Ed Harris, in *Alamo Bay*, is also trapped in the emotions of war. His hatred for the Vietnamese émigrés drives him to attempt murder. His hatred is fueled by the racial bigotry of the KKK and their associated rabble. The seething passion of Ed Harris in *Alamo Bay* is a remarkable contrast to the controlled emotional vengeance of Maurice Ronet in *Elevator to the Gallows*, yet both characters are drawn to their demise by their war experiences. In Homer's *Odyssey*, the fearsome character of the Sirens functions to draw war veterans to their deaths by the attraction of wartime memories. The blanched bones of warriors pile up at the feet of the Sirens who sing of the heroic exploits of the Trojan War. If warriors pause to listen to their songs, they will be trapped there and die.

The Vietnam War was particularly rich in ethnic and cultural differences between the Vietnamese and the U.S. troops. There was the unfinished business created by the U.S. pullout, which gave the veterans of that war a sense of loss that they didn't deserve. The Vietnamese people came to symbolize and be blamed by the failure of U.S. strategy. And then there is the so-called Theory of Cognitive Dissonance that suggests that the more effort and energy and money one puts into a task, the more one has to justify its value. Every war must generate such dissonance. The deaths, the wounded, the suffering, and the financial costs of conducting war generate such dissonance. The more the ambiguity regarding the justification for the war, the more dissonance is created by the efforts expended. And after the war, the war veteran must then deal with the relationship of the memories to the reality of the facts as they come to light. Anger, hatred, revenge, all the emotions generated by combat, the symptoms of PTSD and depression, have to be related to as the product bought by the conduct of the war. One cannot just let them go and walk away as if nothing had happened. ##

WDVA Contractors and Therapists

Steve Akers, MSW, Everett……..….425 388 0281
Clark Ashworth, Ph.D., Colville……...509 684 3200
Wayne Ball, MSW, Chelan & Douglas…509 667 8828
Bridget Cantrell, Ph.D., Bellingham...….360 714 1525
Paul Daley, Ph.D., Port Angeles……...360 452 4345
Duane Dolliver, MS, Yakima...……509 966 7246
Jack Dutro, Ph.D., Aberdeen……...…….360 537 9103
Emmett Early, Ph.D., Seattle……....206 527 4684
Dorothy Hanson, MA, Federal Way……253 952 0550
Tim Hermson, MS, Kennewick……...509 783 9168
Dennis Jones, MA, Burlington…..…..….360 757 0490
Keith Meyer, MS, Olympia……..360 250 0781
Brian Morgan, MS, Omak……....509 826 0117
Dennis Pollack, Ph.D., Spokane……...509 747 1456
Stephen Riggins, M.Ed., Seattle.……..206 898 1990
Ellen Schwannecke, M.Ed., Ellensburg...509 925 9861
James Shoop, MS, Mount Vernon……360 419 3500
James Sullivan, Ph.D., Port Orchard...….360 876 2322
Darlene Tewault, MA., Centralia...…….360 330 2832
Stephen Younker, Ed.D., Yakima.……...509 966 7246

WDVA PTSD Program Director:

Tom Schumacher……. ….……...…360 586 1076
Pager……...… 800 202 9854 or 360 456 9493
Fax……....360 586 1077

King County Veterans Program Contractors and Therapists

Dan Comsia, MA, King County……..253 840 0116
Emmett Early, Ph.D. Seattle……...……..206 527 4684
Joan Fiset, MA, Seattle...……..206 525 4606
Dorothy Hanson, MA., Federal Way ...…253 952 0550
Bruce Harmon, M.Ed., Renton...…….….425 277 5616
Frank Kokorowski, MSW, King County..206 296 7565
Ron Lowell, MSW, Seattle Group…...….425 303 0315
Mike Phillips, Psy.D., Issaquah.....…...…425 392 0277
Dwight Randolph, MA, Seattle..…….….206 465 1051
Tom Wear, Ph.D., Seattle…….……206 527 5382

Director of the King County Veterans Program is Joel Estay.

Frank Kokorowski, MSW, is a King County employee and the Program's full-time clinician.

King County Veterans Program, which also provides vocational counseling and emergency assistance, is located at 123 Third Ave. South, Seattle, WA….206 296 7656.

The King County program works in cooperation with WDVA to provide counseling and evaluations to veterans incarcerated in King County.

To be considered for service by a WDVA or King County contractor, a veteran or veteran's family member must present a copy of the veteran's discharge form DD-214 that will be kept in the contractor's file as part of the case documentation. Occasionally, other documentation may be used to prove the veteran's military service. You are encouraged to call Tom for additional information.

It is always preferred that the referring person telephone ahead to discuss the client's appropriateness and the availability of time on the counselor's calendar. Contractors are all on a monthly budget, however, contractors in all areas of the state are willing to discuss treatment planning .

Some of the program contractors conduct both group and individual/family counseling. ##

The Repetition & Avoidance Quarterly **is published each season of the year by The Washington Veterans PTSD Program, of the Washington Department of Veterans Affairs. The PTSD Program's director is Tom Schumacher. The editor of the *RAQ* is Emmett Early. It is intended as a contractors' newsletter for the communication of information relevant to the treatment of PTSD in war veterans and their families. Your written or graphic contribution to the PTSD Program newsletter is welcomed if it is signed, civilized, and related to our favorite topics of PTSD and war veterans. Contributions may be sent by mail to the Washington Department of Veterans Affairs (Attn: Tom Schumacher), PO Box 41150, Olympia, WA 98504, or by Email directly to <emmettearly@msn.com>. Readers are also invited to send in topical research or theoretical articles for the editorial staff to review. Comments on items reported in the *RAQ* are also encouraged and will likely be published if they are signed. To be included in our mailing list, contact WDVA, Tom Schumacher, or Emmett Early. The *RAQ* can also be read online by going to www.dva.wa.gov Once in the WDVA website, click on PTSD, and once on the PTSD page, scroll to where you find access to the *RAQ*. The newsletter logo is a computerized drawing of a photograph of a discarded sign, circa 1980, found in a dump outside the La Push Ocean Park Resort. ##**